

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2016
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00207253. This visit included a Residential Investigation of Complaint IN00205014.</p> <p>Complaint IN00207253 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F329</p> <p>Survey dates: August 17, 18, 19, and 22, 2016.</p> <p>Facility number: 000100 Provider number: 155191 AIM number: 100266130</p> <p>Census bed type: SNF/NF: 77 Residential: 90 Total: 167</p> <p>Census payor type: Medicare: 14 Medicaid: 40 Other: 23 Total: 77</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 0000	<p>This plan of correction is prepared and executed because it is required by the provisions of state and federal law. Westminster Health Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor are they of such character so as to limit its ability to render adequate care. This plan of correction shall operate as Westminster Health Care Center credible allegation of compliance. This plan of correction is not meant to establish a standard of care, contract, obligation or position and Westminster Health Care Center reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157 SS=D Bldg. 00	<p>16.2-3.1.</p> <p>Quality review completed by 34233 on August 28, 2016.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as</p>				

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	<p>specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician and family of a resident's (Resident #G) multiple complaints or urinary urgency and continuous attempts to transfer self without assist, and failed to follow hospital discharge orders for labs (Resident #J) for 2 of 5 residents reviewed for physician/family notification.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #G was reviewed on 8/18/16 at 3:20 p.m. Diagnoses included, but were not limited to, enlarged prostate and urinary retention.</p> <p>The nurses note, dated 6/16/16 at 11:00 p.m., included, but was not limited to, the following: "...Resident very confused...Excessive attempts to stand up [s with line over it] [without]...Difficult to redirect..."</p> <p>The nurses note, dated 6/17/16 at 3:00 p.m., included, but was not limited to, the following: "...Res [resident] conts</p>	F 0157	<p>(A)What corrective actions will be accomplished for the resident found to have been affected by the deficient practice? Resident #G is no longer a resident of the facility. Resident #J is no longer a resident of the facility. (B) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. All residents with a significant change could be affected. All nurses, who are responsible to call the resident's responsible party and physician, were re-in-serviced to ensure the nurse understands this requirement. Any newly hired nurses will be provided this in-service at orientation. Any nurse who is found not to be in compliance with this education will be re-educated and counseled as necessary with the progressive disciplinary process. (C) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur? All nurses will be re-in serviced on this requirement and will be educated on this requirementat orientation and annually. The Director of Nursing (DON) or designee will check the</p>	09/21/2016

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	<p>[continues] to be confused...Attempts unsafe transfers..."</p> <p>The nurses note, dated 6/17/16 at 10:00 p.m., included, but was not limited to, the following: "...Remains very confused. Continuously attempts to stand up...Requires one on one..."</p> <p>The nurses note, dated 6/18/16 at 12:30 a.m., included, but was not limited to, the following: "...Up at nurses station...kept attempting to climb out of bed. Up in w/c [wheelchair] at nurses station at present time..."</p> <p>The nurses note, dated 6/18/16 at 4:30 a.m., included, but was not limited to, the following: "...Cont [continues] to need one on one..."</p> <p>The nurses note, dated 6/18/16 at 8:30 p.m., included, but was not limited to, the following: "...continues to try to get out of w/c [wheelchair]...Res [resident] does not want to go to bed when asked..."</p> <p>The nurses note, dated 6/18/16 at 10:30 p.m., included, but was not limited to, the following: "assisted to bed...very restless...only abed [in be] 10 minutes before attempting to get back up...Continues to be one on one..."</p>		<p>education sign-in sheet related to this requirement to ensure compliance. In addition, the DON or designee will audit four resident's records for compliance per month. Any nurse who is found not to be in compliance will be re-educated and counseled as necessary with the progressive disciplinary process. All admissions/orders will be verified by 2 nurses to assure orders are accurate. All admissions will be revised by Unit Coordinators or Weekend Supervisors within 24 hours of admission. (D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur,i.e. what quality assurance program will be put in place. The DON's audit findings will be reviewed by the Quality Assurance Performance Improvement Committee(QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year. This will be completed September 21, 2016.</p>	

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	<p>The nurses note, dated 6/19/16 at 7:00 p.m., included, but was not limited to, the following: "...Res [resident] continuously attempting to get [up arrow] [up] out of w/c [wheelchair]...Res [resident] requires 1:1 [one on one]..."</p> <p>The nurses note, dated 6/19/16 at 7:30 p.m., included, but was not limited to, the following: "...Res [resident] [up arrow] [up] in hallway [c with line over it] [with] this nurse [sic] res [resident] requires 1:1 [one on one] [sic] has had several attempts to get out of w/c [wheelchair]..."</p> <p>The nurses note, dated 6/19/16 at 11:00 p.m., included, but was not limited to, the following: "...Res [resident] remains [up arrow] [up] in w/c [wheelchair] @ [at] nurses station [sic] several attempts to get [up arrow] [up]..."</p> <p>The nurses note, dated 6/20/16 at 3:30 p.m., included, but was not limited to, the following: "Resident up most of shift. [name of psychiatric facility] was called for psych [psychiatric] evaluation due to residents one on one..."</p> <p>The nurses note, dated 6/20/16 at 4:00 p.m., included, but was not limited to, the following: "...[name of person] from [name of psychiatric facility] stated to</p>			

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	<p>increase Zyprexa [antipsychotic medication] to BID [twice a day] for now and they will evaluate...on the 8th [July 8, 2016]..."</p> <p>The June 2016 MAR (Medication Administration Record) included, but was not limited to, the following: "...Olanzapine [Zyprexa] [5 mg [milligrams] P.O. [by mouth] BID [twice a day]...dx [diagnosis]...Psychiatric Abnormal Behavior..."</p> <p>The June 2016 MAR included, but was not limited to, the following: "...Olanzapine 5 mg [milligrams] po [by mouth] QHS [every night at bedtime]...dementia..."</p> <p>The clinical record indicated the Zyprexa, 5 mg, was given to Resident #G, twice a day, from 6/20/16 at 8:00 p.m. through 6/27/16 at 8:00 p.m.</p> <p>The nurses note, dated 6/21/16 at 3:00 p.m., included, but was not limited to, the following: "...Resident's behavior still erratic...was still going into other peoples rooms. Resident was positioned by nurses station due to...behaviors..."</p> <p>The nurses note, dated 6/23/16 at 11:45 p.m., included, but was not limited to, the following: "...assisted to bed...several</p>			

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	<p>attempts to get [up arrow] [up] unassisted..."</p> <p>The nurses note, dated 6/24/16 at 2:15 a.m., included, but was not limited to, the following: "...attempting to get [up arrow] [up]...brought to nurses station..."</p> <p>The nurses note, dated 6/24/16 at 3:00 p.m., included, but was not limited to, the following: "...attempting to get [up arrow] [up]...brought to hallway [c with line over it] [with] this nurse..."</p> <p>The nurses noted, dated 6/25/16 at 11:00 p.m., included, but was not limited to, the following: "Cont [continues] to attempt to get [up arrow] [up] [s with line over it] [without] assist numerous times..."</p> <p>The nurses note, dated 6/26/16 at 5:00 p.m., included, but was not limited to, the following: "Resident was up trying to go into other peoples...bathrooms. Resident was going into staff bathroom...Resident constantly request to go to the bathroom..."</p> <p>The nurses note, dated 6/26/16 at 10:00 p.m., included, but was not limited to, the following: "...Has been attempting unassisted transfer all shift...Toileted many times then asks to go to the bathroom again..."</p>			

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	<p>The nurses note, dated 6/27/16 at 5:00 a.m., included, but was not limited to, the following: "...Has been awake all night. Has been toileted numerous times all night but cont [continues] to constantly ask to be toileted..."</p> <p>The nurses note, dated 6/27/16 at 11:30 p.m., included, but was not limited to, the following: "...has had several attempts to get [up arrow] [up] unassisted...has been toileted several times...however will continue to ask to go to the bathroom...required 1:1 [one on one]..."</p> <p>The nurses noted, dated 6/28/16 at 4:30 a.m., included, but was not limited to, the following: "...assisted to bed [p with line over it] [after] toileting...res [resident] has required 1:1 [one on one]...Tried to get up [s with line over it] [without] assist, requests to be toileted constantly even [p with line over it] [after] being toileted..."</p> <p>The physician order, dated 6/28/16, included, but was not limited to, the following: ...Melatonin [medication used for sleep] ER [extended release] 10 mg [milligrams]...po [by mouth] QHS [every night at bedtime]..."</p> <p>The nurses note, dated 7/2/16 at 11:30</p>			

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	<p>p.m., included, but was not limited to, the following: "...has been in...out of bed several times...[p with line over it] [after] toileting res [resident] will ask to be toileted again..."</p> <p>The nurses note, dated 7/4/16 at 3:00 p.m., included, but was not limited to, the following: "...Resident was trying to go into other resident rooms and into staff bathrooms..."</p> <p>The clinical record lacked documentation of physician/family notification related to Resident #G's frequent requests for toileting and continuous attempts to transfer self unassisted.</p> <p>During an interview on 8/19/16 at 3:47 p.m., the Unit Manager indicated Resident #G was one on one due to constantly trying to get up without assist.</p> <p>During an interview on 8/19/16 at 3:49 p.m., the MDS (Minimum Data Set) Coordinator indicated Resident #G was not sleeping.</p> <p>On 8/22/16 at 10:20 a.m., the Administrator provided an undated, current copy of the document titled "Change in a Resident's Condition or Status". It included, but was not limited to, the following: "Policy Statement...Our</p>			

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	<p>facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's condition and/or status...Policy Interpretation and Implementation...1. The Nurse Supervisor will notify the resident's attending physician when:...b. There is a significant change in the resident's physical, mental or psychosocial status...c. There is a need to alter treatment...2. Unless otherwise instructed by the resident, the nurse supervisor will notify the resident's...representative...when: b. There is a significant change in the resident's physical, mental, or psychosocial status..."</p> <p>2. The clinical record for Resident #J was reviewed on 8/18/16 at 3:00 p.m. Diagnosis included, but was not limited to, chronic atrial fibrillation. Resident #J was admitted to the facility on 1/15/16.</p> <p>The care plan for Resident #J included, but was not limited to, the following: "Needs/Problems...At risk for bleeding R/T [related to] anticoagulant therapy...Approach/Action/Plan...3) Labs per MD order..."</p> <p>The hospital discharge summary, dated 1/15/16 at 4:55 p.m., included, but was not limited to, the following: "...[name of</p>			

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	<p>hospital]...[resident #J's name]...[name of cardiologist]...I want a daily INR [test to assess how thin the blood is] to be done at the nursing facility, and I want a CBC [complete blood count] and BMP [basic metabolic panel] to be done in the morning..."</p> <p>The hospital discharge orders, dated 1/15/16 at 5:59 p.m., included, but were not limited to, the following: "...Discharge Orders...daily INR...cbc and bmp in am..."</p> <p>The facility admission orders for Resident #J lacked documentation of the orders for the INR daily and the CBC and BMP due on 1/16/16.</p> <p>Medical Records provided a copy of the document titled PT-INR/Coumadin (Warfarin) Flowsheet on 8/19/16 at 11:50 a.m. The flowsheet indicated INR's were completed on 1/20/16, 1/29/16, 2/1/16 and 2/5/16.</p> <p>During an interview on 8/19/16 at 11:28 a.m., the DON (Director of Nursing) indicated the discharge orders were probably not carried over upon admission to the facility.</p> <p>During an interview on 8/19/16 at 11:30 a.m., RN #6 indicated if the labs were not</p>			

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F 0315 SS=D Bldg. 00	<p>in the chart, then they do not have them.</p> <p>This Federal tag relates to Complaint IN00207253</p> <p>3.1-5(a)(2)(3)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on interview and record review, the facility failed to adequately assess a resident for a toileting program for 1 of 5 residents reviewed for Activities of Daily Living. (Resident #G)</p> <p>Findings include:</p> <p>The clinical record for Resident #G was reviewed on 8/18/16 at 3:20 p.m.</p>	F 0315	(A)What corrective actions will be accomplished for the resident found to have been affected by the deficient practice? Resident #G is no longer a resident of the facility. (B) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. All residents who are at risk for the need of toileting program	09/21/2016

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	<p>Diagnoses included, but were not limited to, enlarged prostate and urinary retention. Resident #G was admitted to the facility on 6/16/16.</p> <p>The care plan for Resident #G included, but was not limited to, the following: "...Needs/Problems...Inadequate control of bladder as evidenced by multiple daily episodes of bladder incontinence...Approach/Action/Plan...C heck for incontinence [q with line over it] [every] 2 hours [plus sign] [and] PRN [as needed]..."</p> <p>The Elimination Assessment Summary, dated 6/21/16 and untimed, included, but was not limited to, the following: "...Assessment of response to toileting program: [Resident #G's first name] has been totally incont [incontinent] of bladder since admission. He is unable to control his bladder...[Resident #G's first name] will be placed on a Q2 [every 2 hours] [check mark] [check] [plus sign] [and] [triangle] [change] [plus sign] [and] PRN [as needed]...6/21/16..."</p> <p>During an interview on 8/19/16 at 2:40 p.m., the Director of Restorative Services indicated Resident #G was incontinent and not on a toileting program. She also indicated the incontinence determination came from the bladder report.</p>		<p>could be affected. This will be determined by the 3 day bladder observation which will be completed upon admission or readmission when significant change in voiding pattern is determined. These are reviewed quarterly, annually and any significant change. (C) What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur. All residents will have an Elimination Assessment Summary and if needed, a toileting program will be put in place. The DON or designee will monitor compliance of Bladder and Bowel (B&B) assessments and documentation through routine rounds and the review of six assessments per month. These assessments will also be evaluated related to the need for a toileting program and the implantation of such, as needed. The nursing team has been provided training related to B&B assessment and documentation and the toileting program process and documentation. Any nurse who is found not to be in compliance will be re-educated and counseled as necessary with the progressive disciplinary process. (D) How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e. what quality assurance program will be put in place. The Director of Nursing or designee will review</p>	

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	<p>The Bladder Report for Resident #G included, but was not limited to, the following: "...all observation between 6/14/2016 12:00 AM and 6/21/2016 2:41 PM...[Resident #G's name]..."</p> <p>6/17/2016"...8:55 AM...Bladder Continenence...[nothing documented]..."</p> <p>6/18/2016"...11:57 AM...Bladder Continenence...incon [incontinent]..."</p> <p>6/18/2016"...2:25 PM...Bladder Continenence...[nothing documented]..."</p> <p>6/18/2016"...11:38 PM...Bladder Continenence...incon [incontinent]..."</p> <p>6/19/2016"...1:07 PM...Bladder Continenence...[nothing documented]..."</p> <p>6/19/2016"...11:47 PM...Bladder Continenence...incon [incontinent]..."</p> <p>6/20/2016"...8:15 AM...Bladder Continenence...incon [incontinent]..."</p> <p>The Bladder Report indicated toileting for Resident #G was only documented 4 times between 06/16/16 and 6/20/16.</p> <p>During an interview on 8/22/16 at 1:20 p.m., the DON (Director of Nursing) indicated there was not enough bladder documentation on Resident #G.</p> <p>On 8/22/16 at 10:20 a.m., the Administrator provided a current copy of the document titled "Policy and Procedure Bladder Continenence", dated</p>		<p>six B&B assessments per month to ensure compliance. The findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI). The findings will be completed monthly and submitted to QAPI for a period of one year. This will be completed September 21, 2016</p>	

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F 0329 SS=D Bldg. 00	<p>6/21/07. It included, but was not limited to, the following: "...Purpose: The purpose of this policy and procedure is to ensure that any resident who enters Westminster Health Care Center and is incontinent of bladder receives appropriate interventions to address correctable underlying causes of incontinence...4. Three Day Voiding Diary. (to be initiated upon admission...)...a. Check the resident every hour and record an observation..."</p> <p>This Federal tag relates to Complaint IN00207253</p> <p>3.1-41(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to</p>				

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	<p>treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to rule out a medical condition prior to increasing a resident's antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #G)</p> <p>Findings include:</p> <p>The clinical record for Resident #G was reviewed on 8/18/16 3:20 p.m. Diagnoses included, but were not limited to, dementia, enlarged prostate, and urinary retention.</p> <p>The June 2016 MAR (Medication Administration Record) included, but was not limited to, the following: "...Olanzapine 5 mg [milligrams] po [by mouth] QHS [every night at bedtime]...dementia..."</p> <p>The June 2016 MAR included, but was not limited to, the following: "...Olanzapine [Zyprexa] [5 mg [milligrams] P.O. [by mouth] BID [twice a day]...dx [diagnosis]...Psychiatric Abnormal Behavior..."</p>	F 0329	<p>(A)What corrective actions will be accomplished for the resident found to have been affected by the deficient practice? Resident #G is no longer a resident of the facility. (B) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents who may need interventions with a significant change could be affected. All nurses, who are responsible to call the resident's responsible party and physician, were re-inserviced to ensure the nurse understands this requirement. Any newly hired nurses will be provided this in-service at orientation. Any nurse who is found not to be in compliance with this education will be re-educated and counseled as necessary with the progressive disciplinary process. (C) What measures will be put into place or what systematic changes will you make to ensure that the deficient practices do not recur. All nurses will be re-educated on this requirement and will be educated on this requirement at orientation and annually. The director of Nursing (DON) or</p>	09/21/2016

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	<p>The nurses note, dated 6/16/16 at 11:00 p.m., included, but was not limited to, the following: "...Resident very confused...Excessive attempts to stand up [s with line over it] [without]...Difficult to redirect...attempted to eat bingo chip..."</p> <p>The nurses note, dated 6/17/16 at 3:00 p.m., included, but was not limited to, the following: "...Res [resident] conts [continues] to be confused...Attempts unsafe transfers..."</p> <p>The nurses note, dated 6/17/16 at 10:00 p.m., included, but was not limited to, the following: "...Remains very confused. Continuously attempts to stand up...Requires one on one..."</p> <p>The nurses note, dated 6/18/16 at 12:30 a.m., included, but was not limited to, the following: "...Up at nurses station...kept attempting to climb out of bed. Up in w/c [wheelchair] at nurses station at present time..."</p> <p>The nurses note, dated 6/18/16 at 4:30 a.m., included, but was not limited to, the following: "...Cont [continues] to need one on one..."</p> <p>The nurses note, dated 6/19/16 at 7:00</p>		<p>designee will check the education sign-in sheet related to this requirement to ensure compliance. In addition, the Director of Nursing (DON) or designee will audit four resident's records for compliance per month. Any nurse who is found not to be in compliance will be re-educated and counseled as necessary with the progressive disciplinary process. Possible medical intervention as well as non-medical interventions will be assessed prior to the increase of antipsychotic medications. (D) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place? The DON's audit findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI) These findings will be completed monthly and submitted to QAPI for a period of one year. This will be completed September 21, 2016.</p>	

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	<p>p.m., included, but was not limited to, the following: "...Res [resident] continuously attempting to get [up arrow] [up] out of w/c [wheelchair]...Res [resident] requires 1:1 [one on one]..."</p> <p>The nurses note, dated 6/18/16 at 8:30 p.m., included, but was not limited to, the following: "...continues to try to get out of w/c [wheelchair]...Res [resident] does not want to go to bed when asked..."</p> <p>The nurses note, dated 6/18/16 at 10:30 p.m., included, but was not limited to, the following: "assisted to bed...very restless...only abed [in be] 10 minutes before attempting to get back up...Continues to be one on one..."</p> <p>The nurses note, dated 6/19/16 at 7:30 p.m., included, but was not limited to, the following: "...Res [resident] [up arrow] [up] in hallway [c with line over it] [with] this nurse [sic] res [resident] requires 1:1 [one on one] [sic] has had several attempts to get out of w/c [wheelchair]..."</p> <p>The nurses note, dated 6/19/16 at 11:00 p.m., included, but was not limited to, the following: "...Res [resident] remains [up arrow] [up] in w/c [wheelchair] @ [at] nurses station [sic] several attempts to get [up arrow] [up]..."</p>			

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	<p>The nurses note, dated 6/20/16 at 3:30 p.m., included, but was not limited to, the following: "Resident up most of shift. [name of psychiatric facility] was called for psych [psychiatric] evaluation due to residents one on one..."</p> <p>The nurses note, dated 6/20/16 at 4:00 p.m., included, but was not limited to, the following: "...[name of person] from [name of psychiatric facility] stated to increase Zyprexa [antipsychotic medication] to BID [twice a day] for now and they will evaluate...on the 8th [July 8, 2016]..."</p> <p>During an interview on 8/19/16 at 3:17 p.m., the Unit Manager indicated there was nothing done medically and psychiatric services were called due to Resident #G being one on one.</p> <p>During an interview on 8/19/16 at 3:47 p.m., the MDS Coordinator indicated psych (psychiatric services) was called for them to come and see the resident (Resident #G) and they gave the order to increase the Zyprexa to twice daily and that they would evaluate...the next time they were here. The MDS Coordinator also indicated she thought the facility obtained a urinalysis initially.</p>			

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R 0000 Bldg. 00	<p>The clinical record lacked documentation of medical interventions prior to the increase in Zyprexa on 6/20/16.</p> <p>On 8/22/16 at 10:20 a.m., the Administrator provided a copy of the current, and undated, document titled "Antipsychotic Drugs". It included, but was not limited to, the following: "Policy Statement...Antipsychotic drug therapy shall be used only when it is necessary to treat a specific condition...3. Antipsychotic's should not be used if one (1) or more of the following is/are the only indication...a. Wandering...c. Restlessness. d. Impaired memory...g. Insomnia...l. Uncooperativeness..."</p> <p>This Federal tag relates to Complaint IN00207253</p> <p>3.1-48(a)(4)</p> <p>This visit was for the Investigation of Complaint IN00205014.</p> <p>Complaint IN00205014 - Substantiated. State deficiency related to the allegations is cited at R0052.</p>	R 0000	<p>This plan of correction is prepared and executed because it is required by the provisions of state and federal law. Westminster Health Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor are they of such character so</p>				

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R 0052 Bldg. 00	<p>An unrelated deficiency is cited.</p> <p>Survey dates: August 17, 18, 19, and 22, 2016</p> <p>Residential census: 90</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 34233 on August 28, 2016.</p> <p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure misappropriation of resident property did not occur and failed to conduct a complete investigation for 4 of 4 residents reviewed for abuse. (Resident #B, C, D, and E)</p> <p>Findings include:</p>	R 0052	<p>as to limit its ability to render adequate care. This plan of correction shall operate as Westminster Health Care Center credible allegation of compliance. This plan of correction is not meant to establish a standard of care, contract, obligation or position and Westminster Health Care Center reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.</p> <p>(A) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident's #B,#C and #D were provided a plastic tool box and a lock to place money or valuable inside. Resident #E is no longer an Assisted Living Resident. Facility does not have keys for residents lock boxes. (B) How you will identify other residents</p>	09/21/2016

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	<p>1. The clinical record for Resident #B was reviewed on 8/19/16 at 9:15 a.m. Diagnoses included, but were not limited to, hypertension and celiac disease.</p> <p>The incident report, dated 6/23/16 at 4:06 p.m., included, but was not limited to, the following: "...Residents Involved... [Resident #B's name]...Description added...Resident alleged that someone took a wood carved cane and \$20.00 dollars from [his/her] apartment...Action Taken...6/24/2016 Interviewed resident. Checked [his/her] apartment for items listed. Started interviewing staff. Encouraged resident to obtain locked security box for money...Follow up added...6/24/2016 Resident was unclear when incident occurred. Staff interviewed and stated they have not seen a cane and did not know where resident keeps money or [bag]. Alleged of theft was inconclusive..."</p> <p>The written interview with Resident #B, conducted by the Director of Assisted Living, with the Assistant Director of Assisted Living, dated 6/24/16 and untimed, included, but was not limited to, the following: "...Res [Resident] stated [he/she] thought it was one day last week when someone took her cane...Location of cane: sitting against the wall near</p>		<p>having a potential to be affected by the same deficient practice and what corrective actions will be taken. All residents have the potential to be affected by the same deficient practice. The Director of Assisted Living will use Resident Abuse Investigation form to include other resident interviews. The form will be completed by Director of Assisted living or designee to ensure all parts of the investigation are completed. This form will include a checkoff for interviews of five other residents to determine whether there are other residents affected by said allegations and deficient practice. (C) What corrective measures will be put into place or what systematic changes will you make to ensure that deficient practices do not recur? A new check off for will be initiated on all alleged reports of abuse. In service was completed on 8/22/2016 for all the theft and missing items on Assisted Living by Corydon Police Department. All residents were asked if they would like a secured lock box. All residents that requested locked boxes will be given to residents with keys. Facility will not have a key. All state reportable reports will be given to Administrator with all investigation reports and the residents' abuse investigation form to ensure all areas of the investigation is complete. (D) How the corrective action will be</p>	

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	<p>kitchen [plus sign] [and] table area...When was the last time you actually saw your cane: [sic] I'm not really sure but someone took it...Can you give the appropriate [sic] date: [sic] Well, no I didn't tell anyone one [sic] but today I was mad so I went to [Marketing Director's first name]...Was the cane missing before or after the leak in your pantry: [sic] I really don't know...When did you [sic] money come up missing: [sic] It was another day before the cane...How much money: [sic] \$20.00, I think I had a 10 [plus sign] [and] 20. [sic] [plus sign] [and] they left the \$10...Are you not sure how much money was in wallet [sic] I think it was 10 [plus sign] [and] 20...Where do you keep: [sic] wallet: [sic] in my [bag]...Where do you keep you [sic] [bag], [sic]...next to me in the draw [sic] of night stand...When was the last time you saw your money. [sic] I'm not sure..."</p> <p>During an interview on 8/22/16 at 11:00 a.m., Resident #B indicated he/she was missing a hand carved cane and twenty dollars. Resident #B indicated his/her cane was against the wall, next to the kitchen, across from the pantry. Resident #B indicated he/she kept money in his/her wallet, in his/her [bag] and in the nightstand next to the bed. Resident #B further indicated he/she always locks the</p>		<p>monitored to ensure thedeficient practice will not recur, i.e. what quality assurance program will be put into place. The Director of Assisted Living or designee will review with Administrator all state reportables. Audits' will be completed quarterly to ensure boxes are secure. All residents will be asked at that time if they would like a box installed, if not already provided. All new admissions will be asked during assessment if they would like a secured locked box with key at that time. This will be complete September 21, 2016</p>	

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	<p>apartment door and has since he/she has been at the facility.</p> <p>During an interview on 8/19/16 at 10:43 a.m., the Administrator indicated an inservice was going to be completed on 8/22/16 at 1:00 p.m. for all the thefts and missing items on the Assisted Living side. The Administrator further indicated he thought other resident interviews were conducted.</p> <p>During an interview on 8/22/16 at 10:00 a.m., the Assisted Living Director indicated she did not interview any other residents related to the incidents because she did not want to put them in a panic.</p> <p>2. The clinical record for Resident #C was reviewed on 8/19/16 at 9:45 a.m. Diagnosis included, but was not limited to, dementia.</p> <p>The incident dated 7/12/16 at 7:57 p.m. included, but was not limited to, the following: "...Residents Involved... [Resident #C's name]...Brief Description of Incident...Resident alleges that \$60.00 (3 \$20.00 bills) is missing from [his/her] apartment. Only \$1.00 bill left. Money was kept in eyeglasses case inside a drawer of [sic] [his/her] buffet table which sets behind [his/her] chair in [his/her] living room. Resident stated</p>			

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	<p>[he/she] doesn't check [his/her] money often except for when [he/she] wants to buy something...Immediate Action Taken...Family verified resident should have about \$60.00...Follow Up... [Resident #C's name] alleges that \$60.00 was removed from [his/her] glass [sic] case. The resident or family is unable to give a timeline when [he/she] actually was given the money and when it might have been missing since the resident seldom checks [his/her] money except when [he/she] wants to spent [sic] some money. All staff verified that resident keeps apartment locked even when [he/she] is in the apartment...inconclusive...Preventative Measures Taken...Encourage resident to keep apartment door locked at all times..."</p> <p>The written interview with Resident #C, conducted by the Assisted Living Director on 7/12/16 and untimed, included, but was not limited to, the following: "...Resident stated that \$60.00 was missing from...apartment [plus sign] [and] had left only \$1. [sic] bill...money was [sic] eye glass case in...drawer of...buffet that is next to...chair in the living room. Resident states...doesn't check...mony [sic] often [sic] only when...wants something...is not sure when the money was given to...Family</p>			

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	<p>verified...had \$60.00 but could not say where [sic] they gave it to...Resident stated it might have been missing for a long period of time..."</p> <p>3. The clinical record for Resident #D was reviewed on 8/19/16 at 9:30 a.m. Diagnosis included, but was not limited to, hearing loss.</p> <p>The incident dated 7/5/16 at 4:01 p.m., included, but was not limited to, the following: "...Residents Involved... [Resident #D's name]...Brief Description of Incident...[Resident #D's name] alleges that someone removed \$40.00 (2 - \$20.00 bills) from [his/her] [bag] somewhere between 6/30/2016 and 7/04/2016...Immediate Action Taken...Investigation process stated [sic]...Preventative Measures Taken...Encouraged resident to keep apartment door locked at all times. Encouraged to keep money in locked box or carry money with...Follow up... [Resident #D's name] stated that...[family member] brought...\$40.00 (2 - \$20.00 bills) on 6-30-2016 and that...had a \$10.00 bill left over from the weekend before. [Family member] verified that...was given that amount of money on 6-30-2016. Most all staff stated resident keeps...apartment door locked...Only time anyone goes into resident's apartment is</p>			

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	<p>for breakfast delivery, trash pickup in the evening and bed check at night...Resident is carrying...money on...person at this time. It is inconclusive regarding alleges theft..."</p> <p>The written interview with Resident #D, conducted by the Assisted Living Director, dated 7/5/16 and untimed, included, but was not limited to, the following: "[Resident #D's name] stated that [he/she] had \$40.00 missing from... [bag], some where between 6/30/16 - 7/4/16. Resident stated...Recieves [sic] \$40.00 from [family member] every week. [Family member] verified per phone call...Resident stated...[family member] came [plus sign] [and] took...out to dinner [plus sign] [and]...wanted to pay on July 4th. When...went to get...money...only Had [sic] \$10.00 left [plus sign] [and]...2 - \$20.00 Bills [sic] were gone. [Family member] had given \$40.00...on 6/30/16. did [sic] not check money until 7/4/16. Res [resident] states...keeps door lock [sic]..."</p> <p>During an interview on 8/22/16 at 11:40 a.m., Resident #D indicated \$40.00 dollars was missing from his/her [bag], which was kept in the nightstand by his/her bed. Resident #D indicated he/she reported the theft and was given a little</p>			

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	<p>toolbox that didn't have a lock. Resident #D further indicated he/she does not always lock the apartment door because his/her door key does not always work.</p> <p>On 8/22/16 at 11:50 a.m., a small, black, plastic toolbox was observed to be bolted on the shelf in the bathroom. The toolbox did not have a lock on it.</p> <p>4. The clinical record for Resident #E was reviewed on 8/19/16 at 2:20 p.m. Diagnoses included, but were not limited to, dementia and Parkinson's disease.</p> <p>The incident report, dated 7/14/2016 at 11:20 a.m., included, but was not limited to, the following: "...Residents Involved... [Resident #E's name]...Brief Description of Incident...[Family member] and [other family member] came to this writer's office and alleged that resident had \$250.00 missing from...billfold. Family is not sure how long ago they had given resident the money or no timeline in which the money was seen last. [Family member] stated...always keeps...money in...billfold. Resident keeps billfold in front pocket of...pants. Resident keeps...apartment door open 24/7. Money was noted missing when family had taken resident to the beauty shop. [Family member] was helping resident get...money out of billfold and there was</p>			

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	<p>only \$11.00...Preventative Measures Taken...Encouraged resident and family to keep resident's apartment door closed and locked. Encouraged family to provide a locked [sic] box for money. Encouraged resident not to keep billfold in pocket of pants on the floor at night time...Follow up...At this time it is inconclusive regarding alleged theft..."</p> <p>The facility did not provide a written interview for Resident #E.</p> <p>During an interview on 8/22/16 at 9:25 a.m., Resident #E indicated he/she was missing money. Resident #E indicated he/she had four \$50 dollars bills, two \$20 dollar bills, one \$10 dollar bill, and multiple \$1 dollar bills. Resident #E indicated someone took all the money except the \$1 bills.</p> <p>On 8/22/16 at 10:00 a.m., the Assisted Living Director provided a current copy of the document titled "General Abuse Policy". It included, but was not limited to, the following: "...Purpose: To prevent, identify, investigate, and report allegations of abuse while protecting the safety of our residents and respecting our residents' rights...Scope: This policy applies to our communities with a healthcare component on-site, including...ALF [Assisted Living</p>			

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R 0299 Bldg. 00	<p>Facility]...Policy: It is...policy to promote our residents' right to be free from...any...form of abuse..."</p> <p>This State tag relates to Complaint IN00205014</p> <p>410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on interview and record review, the facility failed to ensure residents medications were reviewed by the pharmacist every sixty days for 2 of 4 residents reviewed for pharmacy services. (Resident #C and #D)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #C was reviewed on 8/19/16 at 9:45 a.m. Diagnoses included, but were not limited to, dementia, diabetes, depression, and heart failure.</p> <p>The medication regimen review for Resident #C indicated medications were last reviewed on 5/4/16 with no new suggestions.</p> <p>The clinical record lacked a medication</p>	R 0299	(A)What corrective actions will be accomplished for residentsfound to have been affected by the deficient practice? Resident # C andcompleted by pharmacy consultant on 8/29/2016. (B) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. Charts were audited for compliance. Pharmacy consultant completed all charts that were out of compliance. All Residents could be affected by said deficiency. All resident's charts will be reviewed by the pharmacy consultant every sixty days as a provision by Indiana State Regulations. The Director of Assisted Living or designee will follow up with pharmacy consultant prior to consultant exiting facility on which resident charts were reviewed. All charts were audited for compliance by	09/21/2016

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	<p>regimen review which was due in July 2016.</p> <p>During an interview on 8/19/16 at 10:45 a.m., the Administrator indicated the pharmacist had not been in since 5/4/16.</p> <p>2. The clinical record for Resident # D was reviewed on 8/19/16 at 9:30 a.m. Diagnoses included, but were not limited to, hypertension and hypothyroidism</p> <p>The medication regimen review for Resident #D indicated admission medications were initially reviewed on 5/4/16 with no new suggestions.</p> <p>The clinical record lacked a medication regimen review which was due in July 2016.</p> <p>During an interview on 8/22/16 at 10:15 a.m., the Pharmacist indicated the new contract was set up where the visits were quarterly.</p> <p>On 8/22/16 at 10:42 a.m., the Administrator provided a current, and undated, copy of the document titled "Assisted Living Facility Pharmacy Services Agreement". It included, but was not limited to, the following: "...1. Consulting Services. Pharmacy shall provide the consulting and education</p>		<p>Director of Assisted Living; all charts are in compliance as of 8/29/2016, pharmacy consultant completed all reviews on charts that were out of compliance on 8/29/2016. (C) What measures will be put into place or systematic changes will you make to ensure that the deficient practices do not recur? All charts will be reviewed every sixty days per pharmacy consultant. The Director of Assisted Living or designee will follow up with consultant prior to this or her departure. The Director of Assisted Living will obtain a list of all residents charts reviewed. The Administrator reviewed with Pharmacy consultant, the provision in the Indiana State Regulations that requires a review of all residents charts every sixty days. If the pharmacy consultant is found not to be in compliance, he or she will be re-educated, the administrator will be notified and manager of the pharmacy provider (D) How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Assisted Living or designee will review four residents charts per month and check for review of chart and drug regime review for completion every sixty days. The findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI).</p>		

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	services set forth below...(a) On a quarterly basis, or more frequent if required by state law, perform a medication regimen review (MRR) with language specific to assisted living for each Resident...After conducting the MRR, the Pharmacy or Consultant shall provide the MRR report to Customer's Administrator/Executive Director, Director of Nursing or designated staff..'		These findings will be completed monthly and submitted to QAPI for a period of one year. This will be completed by September 21, 2016.		